

TESTIMONY OF ALAN LAZAROFF, M.D.

I. INTRODUCTION

My name is Alan Lazaroff. I have been a practicing geriatrician for twenty years. Currently, I serve as the Director of Geriatric Medicine for Centura Health in Denver, Colorado and as Chairman of the Board for Total Longterm Care, Inc., a PACE project which has been in operation for seven years. Centura is a multi-hospital not-for-profit health system which offers the full array of primary, acute and long-term care services. Our organization is a member of the National Chronic Care Consortium (NCCC) and has developed a special focus on caring for persons with serious and disabling chronic conditions.

NCCC is a national non profit organization representing 33 of the leading edge health care organizations operating integrated delivery systems in the U.S. and Canada. NCCC and its member organizations are committed to testing and implementing innovative models of health care financing and delivery which are targeted to fully integrating providers, professionals and payers at every level of the health care system. NCCC has developed a special focus on the dual eligible population and provides consulting services in this arena to such entities as the Minnesota Senior Health Options Program and the Robert Wood Johnson Medicare/Medicaid Integration Program.

I appreciate the opportunity to testify on behalf of the National Chronic Care Consortium and Centura on a topic of critical importance to the elderly and chronically-ill. As the title of your hearing suggests, financing indeed presents a challenge to those of us serving the elderly, chronically-ill and other persons in need of long-term care services. Our current health care system has long been biased toward acute care services which are but one care component needed by the elderly and chronically-ill. This bias has increasingly undermined quality and cost containment goals as our country's health care problems have shifted from a preponderance of acute care illnesses to an era where chronic conditions are the highest-cost, fastest growing segment of health care.

Yet, while publicly financed health care benefits for primary and acute care services continue to expand, benefits for long-term care services remain nonexistent except for the low-income who can access public assistance after they have depleted all of their resources on costly long-term care services. Until we recognize long-term care services as legitimate health care benefits, and begin to offer them under an insurance model, our delivery system will remain fragmented and the health care needs of the elderly and chronically-ill will continue to go unmet. For these reasons, we applaud the Senate Special Committee on Aging for addressing these critical issues and providing the opportunity to develop a meaningful agenda for long-term care financing and delivery reform. For as we enter the 21st Century, baby boomers need these services for themselves, not just their aging parents.

My testimony today will focus on three areas:

- Barriers to integrating primary, acute and long-term care services for the elderly and chronically-ill and the implications of these barriers relative to cost and quality;
- Three variations on one case study which will illustrate the relationship between financing and care delivery and demonstrate why we must modify our current health care financing and administrative structures to permit positive changes in the way care is delivered; and
- Recommendations for modifying our current financing and delivery structures to better serve the elderly and chronically-ill.

II. BARRIERS TO INTEGRATING CARE FOR THE ELDERLY AND CHRONICALLY-ILL

A. Overview

To date, our health care system has failed to recognize the need for integration of primary, acute and long-term care services in a fashion that:

- simplifies access for consumers;
- offers providers the flexibility to provide whatever combination of services are most appropriate and cost-effective at a given time for a specified population
- recognizes the potential to improve quality and reduce costs through an integrated delivery systems approach and
- takes a long-run view of systems reform and cost-containment.

Managed care approaches hold promise for helping to improve health care quality and thereby rein in the costs of care for the chronically-ill and elderly who often are dually eligible for Medicare and Medicaid benefits. While about 30% of Medicaid and 13% of Medicare beneficiaries are enrolled in managed care programs, however, only 3% of the dually eligible receive services from HMOs and like entities. Federal demonstrations like the Social Health Maintenance Organization and the Program of All Inclusive Care for the Elderly (PACE) and state demonstrations for the dually eligible represent important steps toward better meeting the multidimensional, longitudinal needs of the chronically-ill and dually eligible more effectively. Each of these programs integrate, to varying degrees, the financing and delivery of health and related services for these populations.

Although 26 states enroll the elderly and disabled in risk-based managed care programs, only about 16 states enroll the dually-eligible in such programs. Further, few integrate coverage of long-term care services under capitated payment systems. Even states that are working toward integration of Medicare and Medicaid programs such as Minnesota have not fully integrated the financing and delivery of primary, acute and long-term care services and continue to pay for many long-term care services on a fee for service basis.

B. Systems-Oriented Approach

Historically, the movement toward managed care has been focused on cost-containment through the greater use of preventive services, reduced hospitalization, more prudent use of specialty care physicians and prior authorization of inpatient and specialty services. To improve quality of care and health outcomes and reduce costs, we must move from an acute care to a chronic care orientation; i.e., we must adopt an interdisciplinary approach which recognizes the multidimensional and progressive nature of chronic disease. Care for the same person frequently is provided by multiple organizations with little or no incentive to work together to meet common goals regarding patient outcomes and cost containment. Yet cost containment and quality of life for persons with serious and disabling chronic conditions are significantly dependent upon the full array of primary, acute and long-term care providers working together to prevent, delay or minimize disability progression.

The current system must be restructured to allow providers the flexibility and to offer the financial incentives to more effectively respond to the needs of the chronically-ill, manage their care across time, place and profession, and to use whatever combination of care is most clinically- and cost-effective. Providers must have the ability to make patient care decisions based on clinical judgements about the most effective treatments and settings, not based on which programs and services are reimbursed by a particular payor.

C. Cost Containment through Improved Quality & Outcomes

In moving from a health care approach that focuses on single settings to an approach oriented toward systems integration, new quality assurance measures are necessary. For example, rather than judging a provider's effectiveness in caring for a patient at every stop along the continuum, we should develop tools that measure a person's health care status over the course of their condition. Further, since the goals of serving the chronically-ill typically are directed toward disability prevention, not disease cure, we need quality assurance measures that reflect a different expectation with regard to outcomes.

Quality of care for the elderly and chronically-ill could be enhanced by establishing new guidelines and outcome measures which are designed to identify:

- Risk factors and interventions associated with progression of disability;
- Interrelationships among medical, functional, cognitive, social and environmental conditions;
- Clinical and financial effectiveness of different treatment protocols for specific chronic conditions across settings;
- Patient encounter data across settings; and
- A core data set (i.e., utilization, costs, quality, outcomes, etc.) and methods for managing care across time, place and profession.

D. Payment Reform

For integration to occur under managed care plans, all providers serving the same patients must share in the financial risks and rewards associated with providing care, with all providers working toward common cost and quality goals across the network. We must move beyond containing costs within isolated health care sectors such as hospitals and nursing homes and toward establishing administrative, clinical and financial incentives for managing aggregate costs across time and settings.

Most cost containment strategies, including those involving capitated, managed care financing, focus on short-term cost savings within existing provider structures with separate contracts and risk arrangements. Control is organized around service amount, frequency, and duration for specific care segments, rather than on strategies to reduce aggregate costs over the long-run. There is little if no incentive for providers to collaborate in cost-savings across the continuum of care. This approach is likely to actually increase aggregate costs in the long-run, not decrease them. Even managed care organizations engage in a certain amount of cost-shifting within the system. For example, many HMOs limit their financial risk by passing it on to the providers with whom they contract on a fee-for-service basis. The result is risk management on a piece meal basis by negotiating the lowest-priced contract for each provider or service. The result is a high cost administrative structure and an ineffective delivery model for serving people with chronic conditions.

Policies governing provider practices must be less prescriptive of process and more focused on health outcomes and aggregate cost savings across settings. Federal and state policies must shift from containing costs within each program (e.g.) Medicare and Medicaid - and provider category (e.g., hospitals, nursing homes, physicians, etc.) to containing aggregate costs over the course of a chronic condition. Financial incentives must encourage providers to collectively contain costs and prevent disability progression across time, place and profession. Provider systems should be paid under shared risk arrangements with incentives for achieving cumulative cost and outcome targets. Providers and health plans should receive financial incentives to accept and target the high-risk, high cost populations through risk-adjusted payments, not incentives to shun those with serious and disabling chronic conditions because payment methods do not recognize the higher costs of caring for this population. And for the chronically-ill, this means risk-adjustments which account for functional disabilities and comorbidities, not just the severity of the primary medical diagnosis or condition.

Current payment policies place providers very much in a "catch-22" situation. Those of us operating in systems which have special capabilities for effectively treating the needs of the elderly and chronically-ill, ironically, have a disincentive for promoting these capabilities because current payment policies do not protect us against adverse selection. It seems that health care payment policies have spawned a contest to see who can outwit whom - providers or regulators instead of focusing on the very real needs of one of our most vulnerable populations - the elderly, chronically-ill.

E. Uniform Administration and Oversight

Health care administrative policies and procedures exist for each Federal program and provider setting. Regulations governing eligibility criteria, coverage rules, payment policies and evaluation methods differ across programs categories such as Medicare and Medicaid. Requirements regarding patient assessments, care planning, data collection and record keeping are separately defined for clinics, hospitals, nursing homes and community-based service settings resulting in high costs and care fragmentation. Separate program administration makes it virtually impossible to measure the relative effectiveness of various treatments and interventions.

Policies governing acute and long-term care programs must be made more consistent through strategies such as standardized goals, objectives, service definitions, standards and reporting requirements for programs serving the elderly and chronically-ill. All networks providers should be required to collect a standard set of core data on client characteristics, health status, service use, costs and quality outcomes with a special focus on conditions with long-term service trajectories.

This section of my testimony has summarized the major barriers to integrating primary, acute and long-term care services for the elderly and chronically ill from a regulatory perspective. Following are three case studies which progressively move from a traditional fee-for-service model to a fully integrated model of comprehensive care with pooled financing from the Medicare and Medicaid programs. These case studies are intended to illustrate how financing drives approaches to care and health outcomes and how regulations prevent providers from offering whatever combination of care and services we deem most clinically and cost effective in meeting our patients needs.

III. CASE STUDIES

My patients live with chronic diseases like congestive heart failure, emphysema, arthritis, osteoporosis, diabetes, and Alzheimer's disease. Over time, each chronic condition exacts an increasing toll on functional impairment, sometimes punctuated by catastrophic abrupt losses caused by conditions such as stroke, heart attack or hip fracture. These are themselves the potentially avoidable consequences of chronic disease. In many patients, multiple chronic conditions coexist and interact, generating needs which transcend the boundaries of any single professional discipline. Most of my patients enjoy satisfactory health at any give time, but unless death intervenes first, all of them, and all of us, face a future which includes coping with chronic disease. When chronic disease produces permanent functional impairment which renders us less than fully independent, we will have entered the long-term care population.

The management of chronic diseases and disabilities demands a longitudinal perspective, with emphasis on maintenance or improvement of function and prevention of additional disability. Care can be provided at home, in the office or clinic, in the hospital, in various types of licensed residential facilities such as personal care homes or assisted living facilities, and in nursing homes. The services of doctors, nurses, rehabilitation therapists, social workers, psychologists and nutritionists, among others, may be needed in various combinations at various times. Less skilled staff such as nurse aides are critical as

well. The patient's self-care ability and the quality of his/her informal support network are important but hard-to-measure determinants of the need for formal assistance. A system designed to meet the needs of a person with chronic illness would facilitate coordination of care over time, across settings, and among those of varying disciplines and responsibilities.

Most chronically ill elderly individuals today rely upon a poorly coordinated hodgepodge of programs and services whose operation is driven by complex and inflexible eligibility and payment rules. In some instances, the person is shunted from place to place, offered services which start and stop suddenly accordingly to a logic opaque to the consumer, all the while feeling overwhelmed and fearful of the financial consequences.

From the perspective of a geriatrician, the fee-for-service Medicare system is replete with irrational incentives - and downright disincentives to providing the most appropriate and cost effective care. It was designed to pay for the care of discrete episodes of acute illness, each of which is treated in a single specified setting, using well-defined technological interventions. These interventions result in a return to health until the next episode, but do little to prevent the next incident from occurring. My most important work deals with the management of chronic disease between periods of acute exacerbations. Adjustment of medication, early detection of problems, referrals to and coordination of other services, teaching and counseling - these are the things I spend my time doing. My goal is to avoid acute exacerbations and progressive disability. Acute disease arising de novo is an inconsequential part of my practice. The structure and rules of Medicare, governing areas like billing and eligibility for services, must be meant for someone who does something else.

Much of my most important work is unrecognized and uncompensated. If I hospitalize a patient, I can bill Medicare every day I make a hospital visit- never mind whether this is the most appropriate treatment. If I meet with family members of a patient with Alzheimer's Disease, coordinate the services of several professionals, counsel patients and families about both the benefits and limitations of aggressive treatment, and help my patients cope with the emotional consequences of their illness, however, I can bill nothing. I may be able to improve quality of life at the same time that I reduce inappropriate and unproductive hospitalizations, ICU care and emergency room visits, but the more I focus on preventing or delaying the progression of disability, and the more money I save the Medicare program, the less I am paid. Something is terribly wrong with a system that rewards the unnecessary use of high-cost, high tech services for a patient population that is equally dependent upon a vast array of supportive services and which penalizes practitioners who provide the services needed most, often at a lower cost.

I'd like to illustrate the impact of Medicare payment rules on medical practice and health care decision making by describing how care would be delivered for the same person with the same problems under three different payment approaches. Each approach I describe will progressively add incentives for integration of care across settings. The first scenario assumes the patient's care is financed under Medicare and Medicaid fee-for-service plans with no structure or incentives for service integration or coordination across payers or provider settings. The second approach does a better job of integrating primary and acute care services across settings under a Medicare risk contract, but continues largely to ignore coordination with long-term care services. The third approach describes PACE -- a fully integrated program which pools Medicare and Medicaid funding to provide a comprehensive package of primary, acute and longterm care services without regard to scope or duration of coverage.

Scenario 1: Medicare and Medicaid Fee-for-Service: No Integration

Mrs. G is an 83 year old widow of modest means who lives alone in an apartment. I have been her physician for ten years. Her insurance is Medicare and she also has supplemental coverage. She has a

daughter who lives in another city and a frail older sister who lives nearby. The sisters have helped each other over the years, but this no longer is feasible.

Mrs. G's problems include osteoporosis, arthritis, and hypertension. She walks with a cane. She has fallen several times without injury and has become a bit confused at times, probably from early Alzheimer's Disease. During an influenza episode, Mrs. G becomes ill in spite of having taken a flu shot. She falls at home and calls a neighbor, who brings her into the office. She has been eating poorly, has lost five pounds since her last visit, and is unsteady on her feet. She is more confused than usual and appears mildly dehydrated. It is unsafe to send her home. Her needs could be met in the hospital-affiliated skilled nursing facility (SNF), but Medicare will not pay for the care unless she is hospitalized in an acute care facility for three days first. She is admitted to the hospital where she is given IV fluids and begins physical therapy. One night she becomes agitated and tries to climb over the side rails. She is restrained for her safety.

After three days, with the help of the hospital discharge planner, she is transferred to the lower-cost skilled nursing facility. In fact, we don't know if her care will cost less if we transfer her but the transfer produces more revenue for the hospital system. In addition to getting paid the DRG case rate for Mrs. G's inpatient stay, when transferred to the nursing home, the hospital can begin billing Medicare a daily rate for SNF care. Had she stayed in the hospital a few days longer, payment would have been limited to the flat case rate. The SNF is in a separate building and has a completely different staff. A new medical record is created and Mrs. G goes through a series of assessments by nurses and therapists-many of which already have been performed in the hospital -- and tries to adjust to her new surroundings. Another admission, another history, and additional lab tests are needed because Medicare won't allow providers simply to transfer patient records with the patient to a new setting.

Mrs. G improves and after ten more days is ready for discharge. Concern is raised about her living situation, which is felt to be marginal, but she badly wants to return to her own apartment and familiar surroundings. A visiting nurse, physical therapist, and home health aide are ordered through the home health care agency owned by the hospital system. After a month, although she still is marginal, I am informed that the home health agency will discharge her because of concern about her continued eligibility for Medicare home health benefits. Why did this happen? Because aggressive pursuit of fraud and abuse in the home health care industry has led many providers to adopt a conservative approach to continuation of home health care benefits of a lower intensity which could be viewed as "long-term care" as opposed to post acute care benefits. Of course, provider behavior in this regard will vary based on geographic location since interpretation of HCFA's payment policies varies from region to region.

In my office at Centura, we have the unusual advantage of having ready access to social workers, one of whom is already familiar with Mrs. G. She suggests that we seek to enroll Mrs. G in the Home and Community-Based Services program (HCBS) offered by Medicaid as an alternative to care in a nursing home. After a time she is approved, having satisfied requirements related to financial need (i.e., low-income) and medical necessity (i.e., she is deemed "nursing home certifiable" and absent home health services, would likely be institutionalized at a higher daily rate). Since the hospital's home health agency does not have a Medicaid contract, however, another agency with new staff who is unfamiliar with Mrs. G's history and needs begins serving her. The second agency also has a Medicare contract and quickly calls me to request that I approve a visiting nurse, physical therapist and home health aide, social worker and occupational therapist to be funded by Medicare - in addition to the services provided under the HCBS contract. The request is for the same services that the hospital's Medicare certified home health agency just discontinued due to concerns about denial of claims for ongoing services. This is a classic case of cost-shifting where the Medicaid agency is attempting to shift the cost-burden back to Medicare.

Some months later, Mrs. G falls again at home and is found on the floor by her neighbor. She has pain in

her left hip and can not move her left leg. The neighbor calls 911 and requests that Mrs. G be transported to the emergency room of the hospital where I practice. She is told that Medicare will pay for travel only to the closest hospital. An evaluation in the emergency room of the closest hospital confirms the suspected hip fracture. She demands to be sent to our hospital and is transported by a second ambulance and admitted.

She has surgery on her hip and after three days is transported to the SNF, where she is remembered by the staff. She is confused and has difficulty cooperating with physical and occupational therapy, but makes slow progress. After 15 days she still requires assistance with transfers and walking, and it is clear she will require longer term nursing home care. She is promised that when she improves she can return home. Her daughter chooses a nursing home 17 miles from my office, and her care is transferred to another physician. Although she could be transferred by a wheelchair-equipped van, Medicare will not reimburse for nontraditional medical services like vans, so she is sent by ambulance.

Four months later, her daughter telephones and is irate that payment for the ambulance ride between hospitals was denied by Medicare, resulting in an outstanding bill of \$500. She wants to know why I did not arrange for her mother to be sent to the right hospital in the first place. I promise to write a letter appealing the denial.

Meanwhile, her new physician, Dr. K, sees her each month for a scheduled visit. He is not comfortable with the ability of the nursing home staff to evaluate and treat patients with new problems, and feels he cannot visit frequently enough to supervise the care if she becomes acutely ill. But he has been told that Medicare may not pay him for visits more often than monthly unless he justifies the care with a lot of paperwork. The physical therapist reports that because of her dementia, Mrs. G cannot benefit from therapy so this is discontinued after a week. Later, when Mrs. G develops pneumonia, her physician instructs the nursing home to call an ambulance to take her to the emergency room. While the nursing home is capable of attending to Mrs. G's medical needs, it does not get additional reimbursement for increasing its staffing to provide more care if she becomes acutely ill. The facility will be paid, however, for holding an empty bed when patients are hospitalized. Once again, the misalignment of financial incentives drives Mrs. G's care instead of factors related to her medical needs. Once again, Mrs. G is subjected to a needless discharge and transfer process, further exacerbating her increasingly fragile cognitive health.

She is transported by ambulance to the emergency room of the nearest hospital and admitted under the care of the physician who is on-call for the emergency room for the day. A list of diagnoses and medications is provided by the nursing home, but no information is available about her care or her function before her admission to the nursing home. After a week she returns to the nursing home, having been proceeded through yet another discharge and readmission, but has lost ground. On two other occasions in the next nine months she returns to the hospital, receiving care from a different physician in each instance. She is less functional than ever, increasingly confused, and will reside in the nursing home until her death.

Scenario 2: Medicare HMO Risk Contract: Partial Integration

In the second scenario, Mrs. G has joined a Medicare HMO because she could save quite a bit of money. Since the HMO is a zero-based premium plan, the only cost-sharing requirements are modest co-payments of \$5 for certain services such as physician visits and prescription drugs. Further, the minimal cost-sharing requirements enable Mrs. G to discontinue her Medicare supplemental insurance plan for which she paid in excess of \$1,500 annually for premiums. In addition, at the marketing presentation, Mrs. G was told that the HMO was "just as good as Medicare." In fact, the Medicare HMO provides additional coverage for such benefits as dental visits, eyeglasses and prescription drugs - expenses Mrs.

G paid out-of-pocket under her Medicare fee-for-service plan. Since I serve on the HMO's physician panel, Mrs. G does not have to change doctors. Further, although she is unaware of it, the global capitation structure of the plan allows the provider network considerably more flexibility in caring for her than did the Medicare F'S plan.

Let's consider the same scenario with respect to Mrs. G's episodes of illness under a Medicare HMO plan:

- When she develops influenza, she is admitted directly to the SNF since Medicare HMOs have the authority to waive the 3-day prior hospitalization rule. This direct admission saves the costs of three unnecessary days in the hospital, reduces the administrative burden and expense of a hospital admission and discharge, eliminates the cost of the ambulance as well as a number of reassessments and duplicative lab tests, and eliminates the transfer trauma to Mrs. G which, in the earlier scenario, exacerbated her confusion.
- When she becomes agitated this time, the nurse decides to bring her out to the nursing station while she does her charting instead of restraining her. Nursing facilities are much more "senior friendly" than hospitals because they have a better understanding of elderly persons' needs. Nurses and aides receive education about agitation, confusion and other "behavioral problems" and how to address these problems in a more humane and effective fashion than through the use of restraints.
- Upon discharge to home, a social work case manager is assigned to Mrs. G to assist her with the transition. She visits Mrs. G at home to gain a better understanding of her living situation so that the necessary supports are made available. Where a Medicare F'S plan would not have covered the social worker visit, Medicare HMOs have the flexibility to substitute or provide alternative services. Centura pays social workers out of the physician capitation to help manage care in the community and prevent hospitalizations.
- After two weeks, the plan utilization review nurse questions whether Mrs. G is receiving services that are really long-term care and should not be the plan's financial responsibility. The case manager and utilization review nurse debate the boundaries between Medicare and Medicaid, but services are continued for two more weeks while the case manager works to get Mrs. G enrolled in the HCBS program. Upon approval, a Medicaid certified HMO begins serving her. Again, the home health agency requests that I approve a visiting nurse, physical therapist, home health aide and social worker for Medicare payment. This time, however, I inform the agency that, since they are not a network provider in Mrs. G's Medicare HMO, I cannot approve these Medicare services. The HCBS agency increases Medicaid-funded services somewhat as a result. In the event that Mrs. G does need Medicare funded home health care in the future, however, she will be served by two agencies simultaneously with no attempt at coordination since each agency employs their own staff who are paid by different programs.
- When Mrs. G is discharged from the hospital following surgery for a hip fracture, she is transported to a nursing home by a wheelchair-equipped van which the HMO pays for, unlike Medicare F'S, which sent her in an ambulance at a considerably higher cost.
- While Medicare F'S would pay for only one nursing home visit per month, the HMO will pay more frequently when necessary, enhancing care and very likely preventing a re-hospitalization.
- Although the plan does not bear responsibility for nursing home care, discussions begin about using the plan's resources to enhance the capabilities of the nursing home, so that more problems

can be treated there as an alternative to hospital readmission. For example, some Medicare HMAS dispatch nurse practitioners to nursing homes on a routine basis to assist them with patient care with a view toward improved outcomes.

Scenario 3: PACE: Full Integration of Medicare & Medicaid Benefits

In this scenario, Mrs. G is referred to the local PACE program when her Medicare home health care benefit is exhausted. PACE, or the Program of All Inclusive Care for the Elderly, provides all Medicare and Medicaid health-related services to a population of dually eligible individuals in an integrated manner with a single capitated budget. PACE strives to maintain frail individuals in the community, reducing reliance upon institutional settings such as hospitals and nursing homes. If Mrs. G elects to enroll in PACE, she first must disenroll from her HMO (if any), change her physician, and agree to receive all care for both acute and long-term care needs through PACE. PACE, in turn, will:

- provide or arrange for all of Mrs. G's care needs including hospital care, physician care, medications, home health, and nursing home care if it cannot be avoided;
- dispatch an aide to Mrs. G's apartment for one hour each morning to help her get ready for the day;
- provide the following services at the day care center: bathing, since she cannot manage this task without assistance; access to a physician or nurse practitioner as often as needed; rehabilitation therapy at whatever intensity is needed for as long as required; a noon meal and possibly food to take home at the end of the day.

Mrs. G's services will be provided by an interdisciplinary team which can discuss any urgent issues on a daily basis and which will comprehensively reevaluate her health status quarterly. When she falls and breaks her hip as a PACE participant, her PACE primary care physician visits her daily, a PACE social worker visits her in the hospital the day after her surgery and the physical therapy supervisor visits to begin coordinating Mrs. G's rehabilitation therapies. Each is knowledgeable about Mrs. G's health problems and needs and provide continuity of care as well as emotional support at this distressing time. On the second post-operative day, she is transferred to a community nursing home with which has a PACE contract. Since many PACE participants receive services from this nursing home, PACE staff are often in the facility, again offering continuity. Physical therapy is provided by contracted therapists who work regularly with the program and understand the needs of PACE participants.

Because Mrs. G is confused, her progress is slow. Therapy services are provided less intensively, but for longer than usual since PACE is not subject to the same restrictions on home health care services as Medicare fee-for-service providers. The interdisciplinary team at the day center reviews her status each week. After three months of therapy, she can walk safely with a walker and is returned to her apartment instead of spending the remainder of her life in a nursing home.

Mrs. G is brought to the day center six days weekly, but after a month of further gradual improvement, this is reduced to three times a week. When she later develops pneumonia, she is treated with antibiotics and IV fluids in the day center during the day and in transitional housing operated by PACE for several nights (instead of the hospital per Scenario 1 or the nursing home per Scenario 2). Over the next nine months, she develops a urinary tract infection and dehydration and spends two weeks in the nursing home where she has stayed previously. Her physician and social worker supervise her care in all settings. She does not require hospitalization. Recently she can no longer manage at home and moves to an assisted living facility with which the PACE project works closely. She continues to attend the day center four days each week.

IV. CONCLUSIONS

Chronic disease, the dominant problem in the health care of the elderly, will become an overwhelming concern as America's population continues to grow older. Medicare, our "acute care" system for the elderly, even now deals almost exclusively with chronic disease and its complications and consequences. But the program has not made the transition to a chronic care approach to financing and delivery, nor will this transition be possible absent changes in health care regulations. Chronic disease produces the functional impairment in which the need for long term care has its genesis. Thus, there is an unbreakable link between the treatment of chronic disease in all its stages in the Medicare system and the provision of long-term care through Medicaid. Yet progress toward integration of these two programs has been marginal.

Two strategies for controlling the cost of long term care have great potential: the prevention of disability through better management of chronic disease, and better management of the care of those who require long-term care through more flexible approaches adapted to their needs. Catastrophic illnesses like strokes, hip fractures, and heart attacks can be reduced through treatment of the chronic diseases which produce them. We know how to do this today, but need to operate in a system which promotes prevention and rewards better clinical outcomes. In my view, the fee-for-service Medicare system is a Byzantine tangle of fragmented services and complex, often counterproductive rules. It has degenerated into an unseemly contest between the regulators and the regulated. It rewards overuse and poor results. It provides what is paid for, whether needed or not, and nothing else.

For all its flaws, capitated managed care is a promising development for the chronically-ill. Since those who are sick are costly, the needs of the chronically ill are of exceptional interest to those who bear the financial risk for their care. Prevention of additional disability among those with chronic illness offers the allure of large cost savings which can be realized within a business executive's planning horizon. Investments in care management and population-based approaches, which were unthinkable in the old system, could contain costs by helping people to stay healthier. Integrated systems of care, the progeny of managed care financing mechanisms, can develop information about effectiveness and cost which will support the creativity and risk-taking needed for real reform.

Viewed from ground level, the separation of Medicare and Medicaid is unfortunate. Cost-shifting opportunities produce irrational patterns of care, resulting in lower quality and higher costs for both. The nether region at the boundary between the programs is rife with gaming and anomalies. In fee-for-service, home health agencies provide lots of long-term care in the guise of something else. In managed care, much less home care is provided with the rationale that it is really long-term care. Managed care encourages the flexible use of resources guided by clinical and financial effectiveness rather than reimbursement opportunities. Rather than deciding where to treat a patient, the PACE physician and his interdisciplinary team partners consider what services she needs and how to provide them in the least costly and least disruptive manner. The lessons of PACE have broad applicability to the problems of chronically ill of all ages.

The National Chronic Care Consortium has developed a legislative proposal to address the many shortcomings with our current health care financing and delivery system. Key components of this legislation are summarized below in the form of recommendations for Congressional action. A complete copy of the specifications for this legislation is attached to my testimony.

V. RECOMMENDATIONS

The NCCC currently is working with Members of Congress to develop capacity building legislation to improve health care services for the elderly and chronically-ill and to achieve long-term cost savings through more effective care. Our model legislation is called the Chronic Care Act of 1998: Living Well with Chronic Conditions - A Blueprint for the 21st Century. Below is a summary of key provisions in this Act for which we seek the support from all members of this distinguished panel.

A. Chronic Care Agenda for the 21st Century

To achieve the type of structural transformation of our health care system needed to address the needs of the elderly and chronically-ill and to improve quality of care and reduce costs, we must change the public's perception of the problem. We must create a sense of urgency born out of an understanding of the needs of the chronically-ill. While chronic diseases and disabilities are the highest cost, fastest growing segment of the health care population, our system continues to focus on the acute care system. Our model legislation would shift the focus to chronic disease by establishing a National Commission on Chronic Care charged with:

- identifying the special problems of the elderly, disabled and chronically-ill;
- assessing the aggregate costs of caring for this population well into the next century;
- developing quantitative targets for reducing the prevalence of chronic conditions, improving health outcomes among those who have chronic conditions and decreasing the costs of treating this population; and
- developing options for addressing these problems and meeting established targets.

The findings and recommendations of the Commission would be unveiled at a Chronic Care Summit with participation among consumers, providers, payers, policymakers and regulators. Further, a Clearinghouse on Chronic Diseases and Disabilities would be established to educate consumers and professionals alike on issues related to the nature of and treatment for chronic conditions and to collect and disseminate best practices for a targeted set of conditions.

B. Quality Measurements

The Secretary would be directed to develop methods for measuring quality and outcomes based on a chronic care model where functional capacity or impairments would be as relevant to outcome measures as are medical conditions. Outcomes would be based not on cure, but on preventing, delaying or minimizing disability progression.

C. Financial Incentives

The Medicare Payment Advisory Commission would be directed to study payment issues related to care of the chronically-ill, including an assessment of current incentives for cost-shifting between programs and providers and avoiding enrollment of high-risk populations in capitated health plans. The Commission further would be directed to identify financial incentives which would encourage plans and providers to target high cost, high risk clients, to focus on disability progression and to measure the effectiveness of clinical interventions across programs and providers and over time.

D. Regulatory Barriers

The Secretary would be directed to establish a Task Force on Regulatory Simplification composed of federal and state officials, consumers, providers and other appropriate representatives of the chronically-ill and their providers and payers. The Task Force would be charged with identifying barriers to

integration and developing options for streamlining administrative and oversight regulations across providers and programs, with a special focus on developing uniform standards for Medicare and Medicaid.

E. Prototype Models

A partnership would be established between the Department of Health & Human Services and the Veteran's Administration to develop prototype models for targeted chronic conditions which later would be mainstreamed to other programs and populations. The prototype modeling would include the development include high risk screening and intervention strategies for the chronically-ill and disabled and best practices for a targeted set of chronic conditions such as CHF, COPD, Alzheimer's Disease and diabetes.

Detailed specifications for the model Chronic Care Act are attached. I respectfully request your careful consideration of and support for this important legislation which could provide the basis for fundamentally transforming the way primary, acute and long-term care services are delivered today.